DOCUMENT RESUME

ED 075 736 CG 007 961

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TITLE Assessment and Intervention Focusing upon Specific Styles of Family Interaction.
PUB DATE 72
NOTE 15p.; Paper presented at the American Psychological Association Convention (Honolulu, Hawaii, September 2-8, 1972)

EDRS PRICE MF-$0.65 HC-$3.29
DESCRIPTORS *Adjustment (to Environment); *Adolescence; Communication Problems; Family (Sociological Unit); Family Attitudes; *Family Counseling; Family Involvement; Family Problems; Group Unity; Interaction Process Analysis; *Intervention; Maladjustment; Models; *Therapy

ABSTRACT

This report describes a method of intensive, therapeutic assessment of families. The approach was developed as part of a research effort designed to study coping styles in adolescence. The various steps of the procedure are discussed both from the point of view of therapeutic value as well as from the point of view of findings obtained. A number of the consistently different ways in which families differ in interactional styles from each other when they were divided into four relatively homogeneous subgroups according to the adolescents' problem expression are described. The possible use of such typical patterns of dealing with each other as focal points for brief therapeutic intervention is mentioned. (Author)

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Assessment and Intervention Focusing Upon Specific Styles of Family Interaction

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There often exists a difference in the manner in which a clinician views an adolescent child's emotional turmoil from the way it is viewed by the child's family. The family often considers their child's problems as separate from the family. The clinician tends to view the family -- including the disturbed child -- as a unit. Thus, the symptoms of the disturbed child provide information about the problems that exist within the family unit. The family is considered to be a system within its social net work, a "quasi stable feedback-regulated information processing system" (Lewin, 1947), in which balance is maintained by means of forces operating within the system. The word "forces" in this context refers to all those intra and interpersonal dynamics that exist within a family. The dynamic concepts of psychoanalysis reflect an aspect of scientific knowledge which deals with concepts of energy. More modern science -- upon which is based the notion of the feedback-regulated information processing systems-- views as its prime concept not energy, but information. A vital factor of information is of course communication, and how it takes place. Thus, many forces that operate within a family system are acts of communication taking place within the context of the relationships existing in the family system.

A healthy family system may be thought of as one in which homeostasis is optimum, and all family members enjoy well being. The level of conflict or tension within the family is low. Communication is flexible, and the

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* Paper presented at the Annual APA Convention, Honolulu, Hawaii, 1972.

system is responsive to the environment. In a maladjusted family system, on the other hand, homeostasis is often maintained by a number of maladaptive mechanisms. Communication tends to take the form of no or minimal exchange of information; affect is at times isolated from almost all messages; or, the focus is upon one family member who is disturbed, "causing trouble for all."

Tensions in a family tend to increase when the children reach adolescence. The adolescent strives for autonomy -- the maladapted or "sick" system often fails to adjust. Ultimately, the disturbed family system presents itself to a helping agency such as the psychology clinic at UCLA. The problem, or target child is brought to the clinic for one or a number of reasons, such as parental concern, low grades, battles at home, or upon the recommendation of a probation officer.

Since a number of years now, intact families with a disturbed adolescent are referred to the clinic's family project.[1] This project is research oriented; thus, an intensive assessment of the family that would provide information about the genesis of adolescent psychopathology is of primary interest. Yet because we felt that a family seeking help must experience the receiving of such help, and because we believed that a therapeutic involvement would teach us a great deal more about each family than would a neutral task, the assessment was planned with above considerations in mind. It has proven to be a potent therapeutic tool. At the end of the six week assessment period, a

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[1] NIMH Research Grant #MH-08744, Principal Investigator: Eliot H. Rodnick and Michael J. Goldstein.

family is frequently deeply involved in learning and changing; often the emphasis has shifted from one that focused almost entirely upon the target child to one that includes the entire family unit.

The involvement begins during the lengthy intake interview. The adolescent is invited to talk to the intake clinician first, while the parents are asked to complete a detailed questionnaire regarding their observations of the adolescent's behavior and problems, and to write a paragraph describing the problem in their own words. Thus, while the adolescent has a chance to present his or her side of the story first, the parents' attention is focused upon their relationship with their child.

After this intake session, a team of three clinicians works with the family.[2,3] Thus, when parents and adolescent return for the second appointment, each family member meets his or her clinican who will work with that family member for the duration of the assessment. A brief discussion with all clinicians and family members present regarding tape-recording and video-recording procedures is followed by an individual session, where each family member has a chance to tell his or her version of the problem in private, to his or her clinician. Verbal IQ test, TAT story-telling and a 3-card ink blot test (Z-Test) let each family member experience that we are interested in all of them. The test responses provide the team of clinicians with important diagnostic information that will help them in guiding the family through the remainder of the assessment.

A number of points seem especially important in assessing and planning intervention with the family system point of view in mind, such as questions

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[2]A project staff member and two advanced graduate students in clinical psychology.

[3]If there are two adolescents in the family, we expand the procedure and include both adolescents.

regarding how the system maintains its present unhealthy equilibrium, how to plan establishment of a better adjusted system, as well as how to accomplish such changes within the system so that they may be long-lasting.

Kurt Lewin's notions regarding making changes in ad hoc groups are of relevance as are, in fact, many of his thoughts regarding groups of persons in the social field. Lewin discussed important factors regarding the planning of changes in groups from the dynamic point of view, which apply not only to the ad hoc, but also to the family group. According to Lewin, a dynamic change can be brought about by a change in the system's balance of forces either by an addition of forces upon that part of the system, that welcomes the change, or by a reduction of forces, from the change-opposing end of the system. While the addition of forces tends to increase tension, or conflict, within the system, the removal of oppsing forces serves to remove tension and conflict. In Lewin's theoretical conceptualizations, forces available to the system to oppose desirable change include the forces offered by each individual's internal resistance to change. Lewin further suggested that changes tend to be more permanent when these inner resistances to change have been overcome, since this would remove opposing forces, thus contribute to a lowering of tension within the system. According to Lewin, the giving up of resistance to the changing of a behavior or habit implies a willingness to become aware of habits that may be partially out of awareness, and a willingness to try doing or saying something differently, in unfamiliar and perhaps at first uncomfortable ways. Inasmuch as individual patterns of communicating are very habitual, they are quite often out of awareness of the communicator. Likewise, responses to habitually received messages may also be automatic, i.e., out of the full awareness of the senders. Patterns of communications that have

become stereotyped tend to be so even more. Moreover, such stereotyped patterns often serve more than the content transmission of information (Watzlawick, 1967), such as, for example, an avoidance of involvement, a way to cope with conflict, etc.

In the research project under discussion, the way family members communicate to each other is elicited and examined in a number of different ways. Distinctive differences in what family members say to each other have indeed been observed in the families, in systematic accordance with the kind of problem presented by the target child.

Parental perceptions of the adolescent child's problems in coping with stress, as identified from the intake data and from a problem check list enables us to assign the families to one of four relatively homogeneous groups. The primary features of each of the groups are as follows:

Group I: Aggressive, Anti-Social Adolescent: Poor impulse control and acting out behavior. Some degree of inner tension or subjective distress may be present, but clearly subordinate to the aggressive patterns and poor impulse control which appear to be the predominant behavioral characteristics. These were manifest across a broad range of interpersonal functioning, i.e., in peer relationships, in the family, in school, in conflicts with the law, etc.

Group II: Adolescent in Active Family Conflict: A defiant, disrespectful stance towards parents is prevalent, together with belligerence and antagonism in the family setting; often there are signs of inner distress or turmoil - such as tension, anxiety, and somatic complaints. In contrast to Group I, there are few manifestations of aggression or rebelliousness to authorities outside of the family.

Group III: Passive, Negative Adolescent: Is negative, sullen and shows indirect forms of hostility or defiance towards parents. In contrast to Group

II, overt defiance and temper outbursts are infrequent and there is a superficial compliance to wishes of adults. School difficulties are frequent, typically described as underachievement and with little evidence of disruptive behavior.

Group IV: Withdrawn, Socially Isolated Adolescent: Shows marked social isolation, general uncommunicativeness, few, if any, friends, and excessive dependence on one or both parents. Gross fears or signs of marked anxiety and tension are often present. Much of the unstructured time of these adolescents is spent in solitary pursuits.

Certain general dimensions are implicit in this four-way grouping. First, there is the dimension of the locus of the conflict, whether the behavioral difficulties of the adolescent are restricted largely to within the home or whether they are manifest in the community as well. The aggressive, anti-social and passive-negative adolescents (Groups I and III) are similar along this dimension, because both groups exhibit significant behavioral difficulties outside the home in school and peer relationships, even though they vary in the style of their aggressiveness. Adolescents in the active family conflict and the withdrawn, socially isolated groups are similar in that difficulties within are of primary concern.

Another way of looking at these four groups is in terms of the degree of activity in the manifestations of adolescent behavioral problems. Both aggressive, anti-social adolescent as well as adolescent in active family conflict groups are similarly active and overt in their expression of conflict and dissatisfaction. Both passive-negative and the withdrawn adolescents on the other hand are more passive and covert in the behavioral expressions of

their problem.

We have found that family members in each of the four groups have specific ways of communicating with each other, both when asked to role play a communication to each other in the context of working singly with a clinician, as well as when actually discussing a problem of importance to all with other family members.

The role playing sequence forms a part of the third assessment session, a comprehensive, relatively structured interview. The interview schedule is divided into eight areas that are especially relevant to families with an adolescent:

1. Achievement, such as school performance, adolescent career plans, hobbies, parental expectations for the child.

2. Sociability, i.e., friendship patterns, the adolescent's degree of satisfaction with peer group relationships, parental attitudes towards the adolescent's friends.

3. Responsibility. Expectation of household duties, willingness to pitch in when needed, honesty towards each other, child to parent, or parent to child.

4. Communication. Parent-child talks, presence, frequencies, topics talked about, difficulties in talking with each other.

5. Response to frustration. The adolescent's reaction to limit setting in various situations.

6. Autonomy covers themes related to the adolescent's wish to be on his own, formulate his own plans, reach his own decisions; parental reactions to the adolescent's efforts at gaining autonomy.

7. Sex and dating covers question regarding sex information given to the child when young, present dating habits and feelings about this, parental attitudes, etc.

8. A section on family tone focuses on the life of the family unit. Does the family do things together, is there warmth and affection towards each other?

At the end of each of these areas, the clinician asks the family member to imagine a certain situation as if it were occurring right now. The family member is then asked to role play what he or she would say in the imagined situation. In addition, the family member is also asked to role play the receiver responding to the message. Each 'setting the scene', role-played communication and role-played reply is tape-recorded. When all eight "vignettes" have been completed, each family member is reminded of the problems discussed in each area and is asked to rank the problems in order of importance. The most important problem mentioned, plus three or four other vignettes (according to number of children in the assessment) are then transcribed onto another tape. Space is left after each communication, so that the receiver can record a response.

We found that parents in the two groups where the adolescent's problem expression extends beyond the family, i.e. aggressive anti-social and passive-negative -- role played communications to their children which focused upon their legitimate right as parents to make requests. Parents of aggressive anti-social adolescents emphasized the wanting to do so, such as "I am your parent, and I want you to listen when I talk." Parents of the passive-negative group tended to make strong demands, such as "Dammit, I'm your father, and when you're driving with your father, you do as I say." Parents of adolescents whose problem expression remain primarily within the family, i.e. adolescents in intensive family turmoils and withdrawn adolescents frequently ask questions when asked to role play a message to their children.

Restrictive question, i.e. questions that demand a "yes" or a "no" response, such as "Are you going to try harder?" were asked especially often by the parents of the withdrawn and socially isolated adolescents.

Of the eight problem areas, the problem ranked as most important, plus three or four (depending upon family size) other role played situations are transcribed onto a new tape; space is left after each message so that the recipient can record a response. In the fourth session, such a tape is ready for each family member. The child (or children) will hear messages from both mother and father, and will also hear himself role played by each parent. Each parent will receive messages from the child and hear him or herself role played by the child. Each family member is asked to respond twice to each message; once before hearing the role played reply as performed by the sender, and once afterwards. Each response is recorded immediately following the appropriate measage. At the end of this session, each family member is asked to rate "usual" family relationships on a number of adjectives of the Osgood Semantic Differential Scale.

A comparison between the sender's role played response of what the receiver would say and what the receiver actually said indicates that families in the different groups also differ in their ability to predict what the other might say. Thus, parents and children of the aggressive anti-social adolescents were the best predictors, while parents and adolescents of the withdrawn socially isolated youngsters were least able to do so. Predicting ability of parents and adolescents differed among one group, namely, passive-negative adolescents. The young persons were very good predictors of what either parent would say; the parents were very poor predictors.

In the fifth session, the family is asked to deal with the problems discussed in a more direct fashion. Family members are together in dyads, father-

child, mother-child, father-mother, and then all three, for a brief discussion of a problem that is presented at the start of each of the discussions. The problem is presented by playing to the participants one of the role-played messages and tape-recorded responses. Example: To her clinician, a mother has complained that her son never comes to talk with her. The discussion participants now hear on tape, as she is asked by the clinician to imagine herself sitting at home in the living-room, in her favorite orange chair, as the son enters the room. She is feeling lonely and wants to ask him to tell her about his day. She role plays herself, "Tom, come sit down. Let's have a talk. We never have a talk anymore." The voice of the son is heard next, "Naw, I don't want to talk. I'm too busy." The family members are left alone to discuss their feelings about the issue presented on tape, and to share with each other how they might go about resolving the problem. All their interactions are video-recorded.

He found that the families in the different problem groups differ in how and what they communicate. Differences were found in frequencies with which messages of a certain intent were exchanged during the discussions. Intents of messages were studied along a number of dimensions, such as informing, questioning, controlling, expression of overt hostility, and brief yielding. These findings suggest once again that the distinctive styles of communicating with one another are significant parts of the family system, and considerable contributors to the shaping of particular coping patterns in the target child. Some of the behaviors of the child, moreover, such as the monosyllabic brief yielding of the passive-negative adolescents, quite likely shape the parent to continue approaching the child in a certain way. The cycle is thus self-renewing.

During the sixth session family members are shown a 3-5 minute section of

each type of interaction such as, father-child, mother-child, father-mother, and father-mother-child interactions. After each section is shown, the family members rate the interaction viewed on the same adjectives of the Osgood Semantic Differential Scales used for the so-called "base line rating" at the end of the fourth session. They are then asked to discuss the family seen as if they had watched a TV show and were now discussing the characters. First, each family member is only permitted to talk about the self, in terms of "that mother," "that father," etc. Second, still using this mode of distancing, each family member discusses the other family members. Finally, each person is asked to state what he or she would like to see different in the family just seen, in "that son," "that daughter," "that father," "that mother." Recently, we have been able to have family members carry on this talk in solitude. A TV screen in each room shows the filmed interaction, and subsequently the person who is talking about "that family." Family members are asked to think about what they have learned, since our next session would focus on what both they and we have learned about the family.

This 7th session, our disposition session, is comparatively unstructured. At the beginning of it, however, we ask each family member what he or she has learned about the family during the last six weeks. Answers have ranged from "Everything -- you've taught how to communicate" to "Absolutely nothing." Nonetheless, less than 5% of the 72 families who have participated in the project so far have dropped out once the assessment was underway; of these, one dropout was due to severe illness of the father, and two due to the fact that the appointments at the clinic were used as punishment or threats toward the adolescent child. When the clinician responds with amazement to a family who has learned "nothing" in the six weeks, the family is usually ready to

talk about what, in fact, it has learned. The intensity of the involvement is also apparent from the rarity with which assessment appointments are cancelled, and from the comparative willingness with which the clinic fees are paid. We have also learned that a family needs at least two to three more disengagement sessions subsequent to the disposition session, even if all agree that a referral elsewhere is the best next step for the family. We have learned this by talking again to some of our very early families who were referred to a clinician in private practice or to another helping agency immediately after the assessment; their reaction was one of disappointment and anger about having not had the chance to deal with the new input they had received. At the end of the assessment, families who remain in the clinic for follow-up treatment are already well launched in working on their problems. We have gained the impression that families are truly in family therapy faster than by a more conventional treatment approach.

A number of factors are thought to contribute to the high degree of involvement of our families. The most important of these is perhaps the factor of <u>active</u> participation. We ask each family member to think about and talk about a number of possible problem areas in the family and to specify a difficulty clearly enough for the clinician to create a situation for role playing the vignettes. We ask each family member to decide which of all the problems discussed he considers most problematic, and ask a ranking of all problems. We make sure that the important problems form part of the confrontation discussion session #5, when we ask each family member to reveal his or her feelings about the problem, and to think and talk about a resolution. Subsequently, father, mother and child must take a step back in order to look at the self as if he or she were a stranger -- a task many of our family members find difficult

indeed. It was this factor of active participation by group members that was stressed by Kurt Lewin as being all-important in effecting a permanent change within a group system. Each family system that participates in our project at UCLA receives attention as a group at the same time that each family member becomes involved as an individual with a separate clinician. Participation is thus fostered from two different vantage points.

Another factor is perhaps that each participant hears the other speak in a different context, after having stated aloud what his or her expectations about the receiver's response would be. One aspect of this difference in context is the stimulus reduction in that the receiver is not physically present. Moreover, after having made a commitment regarding the receiver's reaction, there is most likely a greater probability that the sender pays close attention to what the receiver's actual reaction is really like. Since the receiver is not actually present, only his voice is heard, the sender's attention can be focused wholly on the verbal aspects of the communications, free from distractions of a non-verbal nature.

The disclosing of emotionally painful material about observations regarding one's own behavior and the behavior of the other family members as if it were that of unknown persons -- even though difficult at first -- actually helps many families to be relatively open and nondefensive in the discussions about the various problems of "that family" after video feedback.

A further factor is possibly that repeated exposure to one's own ways of communicating is truly a confronting experience. As one mother exclaimed at the end of the video feedback session, "My God, do I talk as harshly as all that?" Unfortunately, a few minutes later she turned to her husband and said:

"It was really your fault. You got me all mad with what you said. That's why I sounded so harsh." This woman's exclamation and subsequent reaction illustrates how and why families benefit from further work. Their responses provide information for future treatment plans -- as do the various typical patterns of communicating found for the different problem groups.

In a recent pilot study, we learned that showing a family specific brief scenes from the confrontation interaction and then asking the family to react each scene, using different ways of talking to each other, has helped one family to work its way out of a frustrating pattern of stereotyped cycles of "why" questions and meaningless responses.

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